VERMONT
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

NUTRIT.1
FORM#20
C: 12.14

Agency of Human Services

~Nutritionals~

Prior Authorization Request Form

Effective February 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Nutritional supplements. These limits and criteria are based on concerns about appropriate use and medical necessity. In order for beneficiaries to receive coverage for nutritionals, it will be necessary for the prescriber to telephone of complete and fax this form to GHS. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Name: _____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy Phone: _____Pharmacy Fax: _____

Nutritional supplement will be administered via Tube Feeding? Yes No (**Proceed to diagnosis question**)

Patient Diagnosis/Condition:

AIDS Chronic Diarrhea Dementia(includes Alzheimer's) Inflammatory Bowel Disease Cancer

Cognitive Impairment Developmental Delays Parkinson's Celiac Disease Cystic Fibrosis

Difficulty with chewing/swallowing food Short Gut Cerebral Palsy Request is for weight loss/low weight or serum protein **(complete appropriate section below)** Other: _____

Unplanned Weight Loss/Extremely Low Weight:

Baseline: Date _____ /_____ /_____ Height: _____ Weight: _____ BMI: _____

Current: Date _____ /_____ /_____ Height: _____ Weight: _____ BMI: _____

Children: Mid-Upper Arm Circumference: _____ Head Circumference: _____

Laboratory Values: Date _____ /_____ /_____ Albumin: _____ Pre- Albumin: _____

Additional clinical information to support PA request:

Requested Supplement: _____

Strength & Frequency: _____

Anticipated duration of supplementation: _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature:_____ **Date of request:**_____

GHS
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